NATIVIDAD MEDICAL CENTER

Friendly People — Family Medicine

1330 Natividad Rd.
P.O. Box 81611
Salinas, Ca 93912
(408) 755-4111

RESPONSE TO OSHPD - REPORT ON HEART ATTACK 1991 TO 1993

Several goals are clearly stated in this 217-page report plus computer diskette. The primary goal is "to improve the quality of hospital care available to all California citizens." This "Report on Heart Attack 1991 - 1993" documents the mortality rate for cases coded as myocardial infarction during those years and, using elaborate techniques to link data bases, is able to capture 30-day mortality rates if patients are coded properly and if they die in California. This is an ambitious project and, given the above variables, collects large amounts of information which is useful as a starting point. It also has pitfalls. It depends on how the data is handled.

It is my thesis that the information in its current form is quite unfriendly to use. If a few more data points are abstracted from charts or if linked to another data base (such as Cooperative Cardiovascular Project from California Medical Review, Inc. (CMRI)), more practical and easily applied information would be obtained to help hospitals and physicians achieve the above goals.

Reviewing the information from the Natividad Medical Center in Salinas, using either model A or model B, our mortality rate is not significantly different than expected from California as a whole. This is also true of two other hospitals in Monterey County with whom we interact.

Currently it is our practice to identify high risk patients in our emergency room, even prior to admission to the hospital, and send them directly to the Cath Lab. I cannot be sure if this information would be captured in this study and yet we are providing state of the art care for these patients with some outstanding results. These patients would otherwise be likely to have poor outcomes. Our hospital would not be given credit for numbers of patients seen and properly treated. Currently these patients are transferred to another hospital for the Cath Lab part of their care.

Also, reviewing the computer diskette, 17 of our 116 patients (15%) had no social security number. Including the hospital medical record number would be very useful to review cases or even see they were included in the data. Also, as the diskette was printed out, all dates of birth are crossed out and do not print. This makes it virtually impossible to use the information. There is no key provided to the various columns so that sex, race, pay source, disposition, etc., are not easy to analyze. In short I find the information difficult to use. I find our ability to identify patients from this information cumbersome and frustrating. To me, this is the start of a work in progress and, if it is to be useful to clinicians, must be decoded significantly. Including medical record numbers would be a large help.

Using this report we only have raw data and a statistical analysis of death rates from myocardial infarction. While this is a hard data point and the ultimate one, it is only a starting point. For research and health care planning activity, it would be logical to look at yearly death rates. This information is already available to you.

As a health care provider, I (and others) need guidance as to how to improve our results. This report would be more helpful if it included a few more data points or merged information with another data base such as the CMRI study alluded to earlier. It would be quite useful to see additional information for Q-wave myocardial infarction (aspirin use, thrombolytic use, PTCA use, ACE inhibitor use, beta blocker use, smoking advice). This points us in a given direction and gives us a "report card" on how we are doing.

Reviewing Table 2.1 of page 6 in the Technical Guide, it seems counter intuitive that "never smoked" is a risk factor for death in myocardial infarction and "currently smoking" has a protective effect. A history of prior CHF and hypertension is also protective. I don't understand this.

In summary, I am pleased that our hospital is not an outlier with a high mortality rate for myocardial infarction. I have some concerns about whether this report captures all our information as cases which have high expected mortality go directly to a Cath Lab. In its current format, this report is of little use to me as I cannot easily identify those patients who died because medical record numbers are not included. We do not code by social security

number and 15% of our patients did not have one. Additional information as alluded to in the body of this response would be helpful. The report is a good starting point and certainly captured my attention. We all wish to improve our treatments.

Thank you,

JOHN SCHATZ, M.D., F.A.C.C.
Chief of Cardiology
Natividad Medical Center

HOWARD H. CLASSEN
CHIEF EXECUTIVE OFFICER
NATIVIDAD MEDICAL CENTER

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